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# EVALUATION OF THE GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION: SECOND SEMI-ANNUAL PROGRESS REPORT

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# EXECUTIVE SUMMARY

The Health Care Financing Administration (HCFA) was charged with implementing a program of Rural Health Care Transition Grants as mandated by Congress through the Omnibus Budget Reconciliation Act of 1987 (P.L.100-203). The goal of this program is to assist rural hospitals in increasing their long-term financial stability and management capacity. Funding of $8,892,000 was appropriated in FY 1989 for the grant program and its evaluation.

Awards of up to 2 years duration and up to $50,000 a year per hospital were made on September 15, 1989, to 181 hospitals, representing 184 grant awards. Grants were awarded based on technical merit and with the goal of achieving geographic dispersion of the available grant funds.

The legislation also mandated reports from the HCFA Administrator to Congress every 6 months on the progress of the program.

This is the second 6-month report. The first report described how grantees were selected and compared the characteristics and projects of grantee and nongrantee hospitals. This report describes the progress of the projects in their first 6 months, including the problems encountered and the approaches to resolving them. This report is based on monitoring reports submitted by the grantee hospitals covering the period September 15, 1989, through February 28, 1990. In addition, information gathered during site visits to two grantee hospitals is presented.

Subsequent to award, three hospitals, Arkansas City Memorial Hospital in Arkansas, Kansas; Breckenridge Memorial Hospital in Hardinsburg, Kentucky; and Wilson Memorial Hospital in Floresville, Texas declined their grants due to key personnel changes within the hospital that resulted in the Board of Directors in each hospital voting to cancel the grant. In March 1990, Salamanca District Hospital in Salamanca, New York ceased operations as an acute care hospital and withdrew from the program. This hospital was a member of a consortium, and this project continues despite the loss of this hospital. As a result of these changes, there are 177 hospitals participating in the grant program at the end of the first 6 months.

Six months after the awards, the majority of the hospitals have started their grant programs successfully. Nearly half of the projects are running on schedule, and none of the projects that are behind schedule are having serious difficulties. Projects that are on schedule, or ahead of schedule, have attributed their successes to the dedication of hospital staff, high levels of community support, cooperation from other organizations, and community

need. Projects that involve inpatient service development or strategic planning are more likely to be on schedule, while those that are developing beneficiary services or long-term care services are more likely to be behind schedule.

The key reason hospitals have faltered in adhering to their schedules has been their inability to hire and retain key administrative and clinical staff. Other factors that have delayed the projects are regulatory constraints, lack of community support, and coordination difficulties.

The hospitals have spent their grant monies slowly, 82 percent of the grantees reported spending less than half of their first year grant award, and 64 percent have spent less than one-quarter. Of the grant funds that have been spent, 66 percent were spent on personnel and capital expenditures.

# I. INTRODUCTION

## A. LEGISLATIVE HISTORY AND PURPOSE OF THE GRANT PROGRAM

Congressional concerns about the problems of rural hospitals and access to health care for the residents of rural areas led to the enactment of the Grant Program for Rural Health Care Transition. In the legislation, Congress mandated that the Health Care Financing Administration (HCFA) "establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

(1) Changes in clinical practice patterns

(2) Changes in service populations

(3) Declining demand for acute-care inpatient hospital capacity

(4) Declining ability to provide appropriate staffing for inpatient hospitals

(5) Increasing demand for ambulatory and emergency services

(6) Increasing demand for appropriate integration of community health services

(7) The need for adequate access to emergency care and inpatient care in areas in which a number of underutilized hospital beds are being eliminated."[1]

[1]Section 4005(e) of Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987.

The legislation further stipulates that "a grant may not exceed $50,000 a year and may not exceed a term of 2 years."[2] Funds may be spent for any expenses incurred in planning and implementing the project with two exceptions: no part of the grant funds may be expended to retire debt incurred before September 15, 1989[3]; and, no more than one-third of the grant funds may be used for capital-related costs. The legislation mandated that grantees had to be non-Federal, nonproprietary, short-term, general acute care hospitals with fewer than 100 beds. Furthermore they had to be paid as rural hospitals under Medicare's Prospective Payment System to be eligible for the program.

The conference agreement on the fiscal year (FY) 1989 HCFA appropriation included $8.9 million to fund this grant program, including the independent evaluation of the effectiveness and impact of the program. There was approximately $8.3 million available in fiscal year 1989 to fund the grants themselves, which allowed 184 grants to be awarded to 181 eligible rural hospitals.

Congress in deciding upon the direction of the Rural Health Care Transition Grant Program for FY 1990 amended Section 4005(e) of the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203) through Section 6003(g)(1)(B) of OBRA 1989. Under the amended grant program, eligible rural hospitals may request up to $50,000 per year for up to 3 years (rather than the previous 2-year limitation). Congress appropriated a total of

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[2]Section 4005(e) of Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987.

[3]Date of grant award.

$17.8 million in FY 1990 to fund the second year of grants awarded in FY 1989, new awards in FY 1990, and the evaluation of the program. This will allow funding for approximately 180 new grants for award in September 1990.

## B. NUMBER OF GRANTS MADE AND ACCEPTED

On September 15, 1989, HCFA awarded 184 Rural Health Care Transition Grants to 181 hospitals. Three hospitals, Arkansas City Memorial Hospital in Arkansas, Kansas; Breckinridge Memorial Hospital in Hardinsburg, Kentucky; and Wilson Memorial Hospital in Floresville, Texas declined their grants due to key personnel changes within the hospital that resulted in the Board of Directors of each hospital voting to cancel the grant. This reduced the number of grants to 181, and the number of participating hospitals to 178. In March 1990, Salamanca District Hospital in Salamanca, New York ceased operation as an acute care facility. This hospital was a member of a consortium project, and the project continues despite the loss of this hospital. As a result of these changes, 177 facilities were participating in the grant program 6 months after the grants were awarded.

## C. PURPOSE OF THIS REPORT

Congress mandated in OBRA 1987 that the HCFA Administrator report to Congress on the progress of the funded projects every 6 months. The first report described the grantee selection process and compared the grant winners with the nongrantee hospitals.

This is the second report on the grant program. Grantees are being monitored through telephone contacts, site visits, and the submission of reports by the grantees

describing their expenditures and progress in meeting their goals. This report describes the progress of the FY 1989 grantees after 6 months, based on the reports they submitted covering the period September 15, 1989 through February 28, 1990 and visits by the evaluation contractor to two grantee hospitals. This report describes expenditures by grantees, problems encountered, and the reasons for successful start-ups (based on self report). A more detailed discussion of the progress of the two hospitals visited in the first 6 months completes the report. During the two site visits, grant financial records were reviewed and key personnel who administer or are affected by the grant projects were interviewed.

## II. DESCRIPTION OF THE PROJECTS' PROGRESS

### A. INTRODUCTION

In OBRA 1987, Congress mandated that HCFA report to Congress on the progress of the rural health care transition grantees every 6 months. A monitoring process was designed to ensure that grant funds were expended in a manner consistent with achieving the project goals and in accordance with regulations and to inform both HCFA and the Congress on the use of grant funds under the program, and on grantees' progress towards meeting their goals.

The monitoring process incorporates three activities. First, grantees must submit a report every 6 months that describes their progress and documents grant expenditures. Second, grantees are contacted periodically by the HCFA project officer to check on the status of the project and follow-up on any problems that have been identified. Finally, site visits will be made to 50 of the FY 1989 grantees. These site visits will allow progress on the project to be verified as well as provide an opportunity to review financial records on grant expenditures on personnel and capital equipment. Six-month monitoring reports and the site visits will also provide information needed for the program evaluation mandated by Congress.

Under the terms and conditions of the grant award, grantees are required to report the amount of grant funds spent and the progress made on their project every 6 months. The first report, which covered the period September 15, 1989, through February 28, 1990, was due on May 7, 1990. Of the 178 grantees that were required to report for this time

period,[4] 135 completed reports in time to be processed for this Congressional report. The remaining grantees submitted reports late, without the necessary supporting documentation, or with discrepancies that could not be resolved in time for inclusion in this report. Six grantees had not filed a report as of July 1, 1990. The information presented below is based upon the 135 completed reports or 76 percent of all grantees.

## B. PROJECT IMPLEMENTATION

### 1. Overview

Looking at the progress of the 135 projects 6 months after award, 7 percent of the projects were ahead of schedule, 46 percent of the projects were on schedule, and 47 percent were behind schedule by more than 1 month. There appears to be a correlation between being on schedule and the position of the person administering the project. Hospital administrators direct the largest percentage of grant projects (56 percent), and 61 percent of these projects were on or ahead of schedule. A small number of projects (13 percent) are directed by multiple project directors, and while none of these are ahead of schedule, over half (53 percent) are on schedule. In contrast, only 39 percent of projects that have been delegated to another staff member or an outside consultant were on or ahead of schedule. (see Table II.1)

[4]Salamanca District Hospital filed a report, which is included in the 135 completed reports, since its withdrawal was not until March 1990 and this reporting period ended February 28, 1990.

## TABLE II.1

## DISTRIBUTION OF PROJECT TIMELINESS BY PROJECT DIRECTOR

| | Total | Ahead of Schedule | On Schedule | Behind Schedule by More than 1 Month |
|---|---|---|---|---|
| Project Directed by the Hospital Administrator | 74 (56%) | 6 (8%) | 39 (53%) | 29 (39%) |
| Project Directed by Another Staff Member of Outside Consultant | 41 (31%) | 4 (10%) | 12 (29%) | 25 (61%) |
| Multiple Project Directors | 17 (13%) | 0 (0%) | 9 (53%) | 8 (47%) |
| Total | 132 | 10 (8%) | 60 (45%) | 62 (47%) |

NOTE: Row percentages in parentheses.

NOTE: Three hospitals were not included in this chart, because the project director was not identified in the semi-annual report.

Progress in meeting schedules varied slightly among projects with different objectives. (See Table II.2.) Fifty-three percent of the projects overall were on or ahead of schedule. While there were only a small number of inpatient service projects, 71 percent of these projects were on schedule, thereby exceeding the overall rate. Of the five inpatient service projects that were on schedule, two were still in the planning phase, and two were able to recruit a clinician without any difficulty. The planning and development projects slightly exceeded the average, with approximately 58 percent of these projects on or ahead of schedule, which is not surprising since they depend to a great extent on existing staff resources. The lowest rates of meeting the schedule were found among the beneficiary service projects (44 percent on or ahead of schedule) and the long term care service projects (43 percent on or ahead of schedule). There appear to be more obstacles to introducing a new service than to planning a project. Hospitals introducing a new service reported problems such as delays in administrative approvals (for swing beds and construction) and difficulties hiring staff to administer the program or provide the services.

We find projects at many different points in their development. Fourteen percent of the grantees had planned the steps necessary for implementing their projects prior to receiving their grants so these grantees were able to move quickly once they received their monies. Twenty percent of grantees also got off to expedient starts because projects for

TABLE II.2

PROJECT SCHEDULES BY PROJECT OBJECTIVE

| Project Objective | Ahead of Schedule | On Schedule | Behind Schedule by More than 1 Month |
|---|---|---|---|
| **Services** | | | |
| Beneficiary Services | 3 (8%) | 14 (36%) | 22 (56%) |
| Inpatient Services | 0 (0%) | 5 (71%) | 2 (29%) |
| Outpatient Services | 5 (10%) | 24 (45%) | 24 (45%) |
| Long-Term/Home Health Care | 2 (8%) | 9 (35%) | 15 (58%) |
| **Health Planning and Development** | | | |
| Strategic Planning | 2 (6%) | 18 (53%) | 14 (41%) |
| Staff Development | 3 (7%) | 21 (49%) | 19 (44%) |
| **Total** | 10 (7%) | 62 (46%) | 63 (47%) |

NOTE: Column percentages in parentheses.

NOTE: Because any applicant may develop a proposal with more than one objective within a given grant category, the number of projects may add to more than the total.

which these hospitals were awarded monies were developed to augment or build upon a service the hospital already offered.

2. Start-Up Successes and Difficulties

Successes - The two factors that contributed to projects running ahead of schedule were success in recruiting the necessary administrative or clinical personnel, (five projects) and higher-than-expected demand for new services (three projects). Of the projects that were ahead of schedule in recruiting, two hired physicians, one hired a new chief executive officer, one a nurse manager, and one recruited community volunteers, all sooner than expected.

Two hospitals provided examples of discovering a greater demand for services than they had anticipated in planning their projects. One hospital planned to serve 600 Medicare patients in its physical therapy program over the 2-year grant period. However, in the first 6 months, the program had already provided services to 307 Medicare patients, and the hospital has revised its projections accordingly. Another hospital developed a health screening program for which moderate patient service goals were projected. When the hospital began screening patients it found it was having difficulty in keeping up with the demand. The conclusion this hospital has drawn is that, while Medicare residents are concerned with their health, many community members cannot afford preventive care. In general, projects that are ahead of schedule appear to be implementation projects that responded to an unmet need within their community.

Difficulties - Lack of key personnel was the reason most frequently cited for delays in the schedule. Many projects required the hiring of a coordinator or other key staff, without whom the project cannot be implemented. Hospitals found it difficult to identify qualified applicants for the job, and many have not hired anyone. In addition, hospital administrative staff turnover has caused management difficulties at many grantee hospitals. New administrators find it difficult to direct a project at the same time they are learning the job. Consequently, a few hospitals have delayed beginning their projects, and some have slowed down the project's implementation.[5]

3. Operational Successes and Difficulties

Successes - The majority of hospitals have started their projects successfully. Grantees cite numerous factors that have contributed to the projects' success:

- o Availability of grant funds (cited by 47 percent)
- o Cooperation with a Government agency or another provider (cited by 44 percent)
- o Dedication of the hospital staff (cited by 36 percent)
- o Community support (cited by 33 percent)
- o Filling a community need (cited by 20 percent)

[5]Three of the hospitals that declined their grants declined due to key personnel changes.

The grant monies were considered a major factor in project success for two reasons. First, winning the grant bolstered the hospital's image in the community. In turn, the community support for the hospital increased and hospital staff morale improved. Second, the grant allowed the administrator to undertake tasks that he or she never had the time or the money to do. Due to the grant funds, hospital administrators and board members are taking the time to plan their futures, consult with their staff, and consult with their communities. As one grantee noted, "personal" touch in communications can lead to greater cooperation in a hospital community, but it takes a great deal of time. The grant funds justify taking this time during a period when minimizing costs is an over-riding concern.

Cross-organization support took a number of forms. State agencies such as Offices of Rural Health, Public Health, and Planning Departments have helped grantees, as have local agencies as diverse as the County Commission and the Fire Department. For example, one hospital, which is upgrading its emergency services through the purchase of new equipment, has had a cooperative relationship with its county commission (which is also contributing $20,000 to the project). Another project, which is planning and implementing a rural health clinic, has received guidance from the State department of public health and a university-based State rural health center has facilitated the hospital in planning its project.

Cooperation with other providers has been an important source of success too. This cooperation ranges from the successful implementation of a teleradiology system in a consortium, through guidance and support from managing hospital systems, patient referrals,

staff education provided by tertiary medical centers, and friendly support from local agencies on aging and area physicians.

Dedicated hospital board members, administrative staff, and clinical staff were frequently cited as a reason for project success. One hospital, for example, is converting part of the hospital to a swing-bed unit and, to help with the conversion, an "Adopt a Room" program was started by the hospital board. The board members contacted local organizations and businesses and asked them to provide supplies and labor to "spruce up" a hospital room. This involvement by the board has strengthened the hospital's public image because the community views this effort as an indication that the hospital plans to remain open.

Both financial and in-kind community support were cited as contributing to project success. Most of the support has been relatively small contributions, such as free advertising by the local newspaper, volunteer work with the profoundly handicapped, and so forth. A hospital in Ohio has a project to implement a mobile cardiac risk intervention program, and a local doctor volunteered to process cholesterol test results on his personal computer, insuring effective and efficient patient follow-up. On a larger scale, one hospital, whose project goal is to open a 64-bed skilled nursing facility (including some converted acute-care beds), has received over $1 million in pledges for the building fund drive. These types of support, whether small or large, have helped the grantees start the operation of their projects smoothly.

Finally, 20 percent of the hospitals commented that their project was off to a successful start because it filled a need in the community. Grantees who cited this factor were those pursuing health professional recruitment or service provision projects. In these cases, high demand for the practitioner or the new service has provided a solid beginning for the project.

Difficulties - While many hospitals noted a variety of factors contributing to success, problems have also been encountered. The predominant problem is lack of success in recruiting or retaining personnel. One-third of the hospitals stated they were having a recruiting or retention problem; more than twice the percentage of any other problem. Hospitals have had problems recruiting both administrative and clinical personnel. Projects have been delayed both because a project coordinator could not be recruited and because of changes in hospital administrators. Many hospitals have had difficulty recruiting clinical staff who are critical to project implementation and some have lost clinical hospital staff; this, while not directly impacting on the project, has also caused project delays. For example, one hospital lost five physicians from its local service area, so the project coordinator was spending virtually full time on physician recruitment rather than implementing a planned community survey. The grantees are documenting the increasing urgency of staffing problems that face nearly all rural hospitals.

Eleven percent of the hospitals have discovered that complying with local, State, and Federal regulatory requirements often takes more time than they had projected in developing their projects, and therefore the implementation of the project has been delayed.

This has been particularly true for those hospitals that have sought Certificate of Need (CON) and licensure approval. In one case, the grantee is implementing a rural health clinic in an area in which CON approval is no longer required after July 1, 1990. The grantee determined it would be quicker and less expensive to wait until CON approval was no longer needed than to try to obtain approval. A different example of this type of delay is an emergency communications system that is waiting for a radio frequency assignment from the Federal Communications Commission.

Thirteen percent of the hospitals have had difficulties that the grantees have interpreted as a lack of community support. In most cases the lack of community support for the project reflects a community preference for another hospital. As one hospital noted, the community believes that "bigger is better" and, as a result, chooses to travel to large hospitals in neighboring communities to receive health care. These grantee hospitals had been hopeful that the community would be receptive to new services implemented as a result of the award. Unfortunately, the demand for new services appears to be inadequate for supporting a successful program.

Thirteen percent of the hospitals had problems coordinating with other organizations. These problems typically arose when hospitals expanded their services to include services already available from other providers or organizations. These groups were uncomfortable sharing the market with the hospital and did not wish to cooperate. There are instances when the hospital can work with the other providers or organizations and they will eventually see the value of the hospital's goals. While this is fortunate, hospitals are still delayed as

a result. For example, one hospital planned to coordinate ambulance services and emergency medical personnel training. At first, the local rescue squads did not want the hospital involved in emergency transportation services, which resulted in the local county government's expressing concern about the plan. Despite the initial skepticism, the program has started training emergency medical technicians, and relations with the rescue squads and county government have improved.

Funding problems have delayed but not stopped three hospitals' projects. One of these hospitals was relying partly on outside funds which had not yet been made available, so the grant project was delayed, but the hospital expects to catch up within a few months. Another hospital found its plans and specifications for a long term care facility resulted in construction bids that were significantly higher than the available funds, so the plans had to be respecified and new construction bids had to be solicited. The third hospital found it necessary to reallocate spending within the project and has deferred planned capital expenditures.

## C. CHANGES IN THE SCOPE OF WORK

To date, one hospital has submitted a request to HCFA and has been approved to make a major change in the scope of its project. The hospital had originally proposed introducing case management services for seniors as well as training homemakers and implementing a support group for informal in-home caregivers. As a result of financial losses in 1989, the hospital appealed to the county government for financial support. A

subsequent referendum on a tax increase to support the hospital was voted down in local elections by the community. As a result, the hospital believes that service expansion is no longer appropriate and has requested the grant funds be reallocated to an assessment of the types of services that can be provided by the facility, such as operating as a primary care center.

Several hospitals have requested minor reallocations of grant funds from one project goal to another. One hospital, for example, had intended to use the grant to develop an outpatient chemotherapy unit. The hospital medical staff convinced the hospital administration that outpatient chemotherapy would be an inappropriate service for this hospital to provide. This hospital has requested a reallocation of the $2,500 it had budgeted for this project goal. The hospital now has plans to use these monies to develop a hospice unit.

## D. EXPENDITURES

HCFA awarded $8,254,443 in first year Rural Health Care Transition Grants to 181 hospitals in September 1989. With the hospitals that have left the program, the obligated grant funds decreased to $8,109,828[6]. As of February 28, 1990, after 5 1/2 months of operation, $1,859,301 was reported as spent by the 135 reporting hospitals, accounting for 23 percent of the fiscal year 1989 allotment.

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[6]These amounts include the $5,385 spent by Salamanca District Hospital prior to its closure.

Figure II.1 shows the grant expenditures in the first 6 months by expenditure category. Eighty-two percent of the grant expenditures fell into three categories:

- Personnel: $686,794 (37 percent)
- Capital: $540,892 (29 percent)
- Contracts: $294,404 (16 percent)

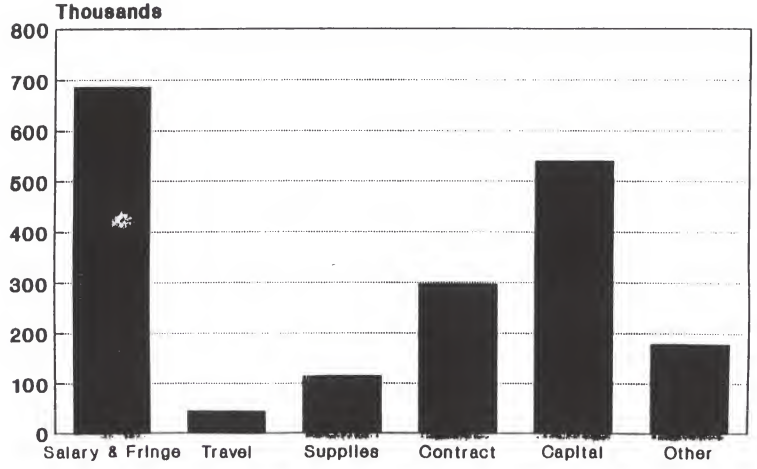
Personnel expenditures include direct labor and fringe benefits. Salaries were paid out of the grant funds for a variety of purposes including: the provision of services (such as an emergency room physician), coordinating the grant, staff recruitment, and staff training.

Capital expenditures were for equipment and construction or renovation. Fifty-seven hospitals purchased equipment such as transportation vehicles, mobile x-ray units and communications equipment. Eleven hospitals spent grant monies on construction or renovation. Three hospitals were planning construction, so their expenditures were for soil testing, architectural services, and site selection. The other eight hospitals had begun construction on a variety of projects, including outpatient clinics and nursing home facilities.

Contract expenditures include expenditures on consultants, building contractors, and in some cases, physician services[7].

[7]In some States it is illegal for hospitals to employ a physician. In these States physicians provide services to hospitals as private contractors, not as employees.

# Figure II.1
## SUM OF INDIVIDUAL GRANT EXPENDITURES
### THROUGH FEBRUARY 28, 1990



Most grantees spent their grant funds slowly in the first 6 months. Had the hospitals apportioned their grant expenditures evenly across the first year, they would have spent about 50 percent of their first year's funds at this juncture. In fact, as Figure II.2 shows, 64 hospitals (or 47 percent) had spent less than 25 percent of their first year grant allocation, and 111 hospitals (or 82 percent) had spent less than 50 percent. There were 10 hospitals that had not spent any of the their grant monies.

Of the 64 hospitals that had spent less than a quarter of their first year grant funds, 35 were on or ahead of their planned schedule (see Table II.3). These 35 hospitals had planned to spend only a small proportion of their grant funds early in the project. On the other hand, 29 of the low-spending hospitals had planned to spend more but had run into difficulties that had delayed their projects by 1 month or more. A further illustration of the reasons for the variations in grant expenditures can be seen in looking at the extremes: the 10 hospitals that had spent no grant monies and the 8 hospitals that had spent more than three quarters of their first year grant funds.

The main reason cited by the 10 hospitals that did not spend any grant funds was that the hospitals had had difficulty starting their projects (see Section B.2). Additionally, 9 of the 10 hospitals had alternative sources of funds available to them for start-up costs, such as foundations and local business organizations. However, only three had used these funds, and these had used them only to a limited extent (an average of $5,725).

On the other end of the expenditure distribution, eight hospitals spent more than 75 percent of their first year allocation and one hospital exhausted its grant funds.

# FIGURE II.2

## PERCENTAGE OF 1ST YEAR FUNDING SPENT

### AS OF FEBRUARY 28, 1990

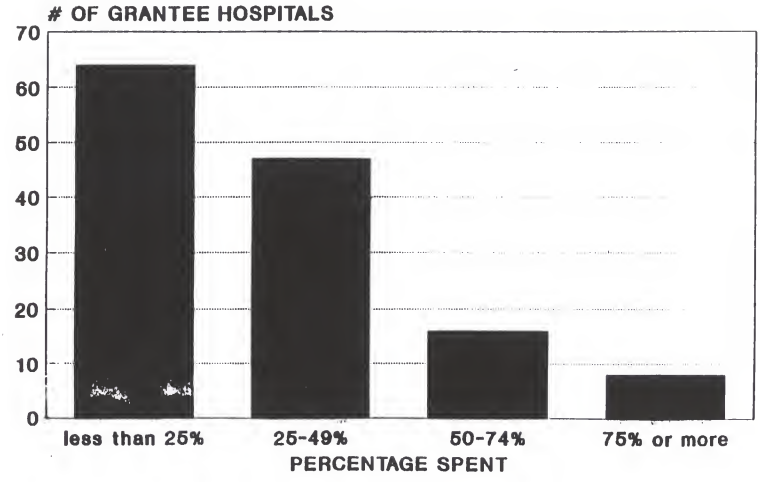


TABLE II.3

PERCENT OF GRANT FUNDS SPENT
BY PROJECT TIMELINESS

| Percent of First Year Grant Funds Spent | Ahead of Schedule | On Schedule | Behind Schedule by More than 1 Month |
|---|---|---|---|
| Less than 25% | 4 (6%) | 31 (48%) | 29 (45%) |
| 24 - 49% | 4 (9%) | 19 (40%) | 24 (51%) |
| 50 - 74% | 1 (6%) | 8 (50%) | 7 (44%) |
| 75% or greater | 1 (12%) | 4 (50%) | 3 (37%) |
| Total | 10 (7%) | 62 (46%) | 63 (47%) |

NOTE: Row percentages in parentheses. These percentages may not add to 100% due to rounding.

Five of the eight hospitals had planned heavy expenditures early in the grant and were on schedule, the other three were a month or more behind schedule. These high spending rates were primarily driven by large capital or contractor expenses. Among these eight hospitals, the average expenditure for capital and contractors was $19,602, in contrast to $5,358 for the remaining grantees. Capital expenditures were for nursing homes and assisted living facilities (three hospitals), emergency room remodeling and construction (one hospital) and teleradiology units and laboratory equipment (four hospitals). In three of the hospitals, feasibility studies by outside consultants were a large part of the expenses.

## III. CASE STUDIES

A rigorous case study approach, or process analysis of the hospitals under the grant program, is the best way to determine the way in which the projects were developed and implemented as well as their impact and effectiveness. The intent of the case studies is not only to monitor the grantees but to provide comprehensive information for the evaluation of the program and the development of the guide for rural hospitals. The site visits provide a structured framework for acquiring information in the following areas:

- o Development of the grant application
- o Demographics and service utilization patterns and needs of the community before and after the grant
- o Financial issues such as the hospital's financial viability and use of grant monies
- o Management structure of the hospitals
- o Staffing issues
- o Degree of community involvement
- o Hospital experience with the grant and the impact of the program
- o Indirect impacts of the project on other providers and the community

In order to get a comprehensive assessment, interviews are conducted with grantee hospital personnel, including the hospital administrator and project manager, clinical staff

involved in the project areas, and financial and accounting staff, the hospital's Board of Directors, other community providers and community groups involved in rural health issues, and local and State government staff.

A sample of 50 hospitals will be selected for site visits over the 2-year period of the projects, with 20 of those site visits to occur during the first year of operation. The sample selected is to be stratified on various criteria to allow a representative cross-sample of grantees. Two of the grantees were visited during December 1989 and January 1990. Although this was early in the program for gauging the impact of the projects on the hospitals and their communities, the visits provided the opportunity to field test the interview protocols and procedures and to review the start-up and implementation of the projects developed by these hospitals.

## A. BACKGROUND

### 1. Hospital Descriptions

The two Rural Health Care Transition grantee hospitals visited in the first 6 months are both located in mountainous regions of the Northeast, in areas where agriculture, light manufacturing, and construction are the predominant sources of income. Although the economic conditions in the two local areas are similar, the financial conditions of the two hospitals contrast sharply largely because of the differences in competition from other hospitals. One hospital is financially sound. This hospital is the major source of health care

for community residents. The nearest large hospital is located 1 hour away. Community support is strong as evidenced by a successful community fund drive that raised $1.5 million to set up a foundation to purchase medical equipment for the hospital. The other, financially troubled, hospital is located just 30 minutes away from a large medical center with an excellent reputation. This hospital has been operating in the red for several years and has recently cut back services in order to cut costs, which has included closing the emergency room between 11 p.m. and 7 a.m.

2. Project Objectives

In implementing their grant projects both hospitals had the same overall goal: to improve their financial strength by developing services that are presently unavailable in the area. However, the projects the two hospitals are implementing with their Rural Health Care Transition Grants are quite different. The financially sound hospital proposed to use the grant as "seed" money to plan or implement numerous different programs, including recruiting a psychiatrist, hiring a coordinator for discharge planning services, starting a swing-bed program at the hospital, and conducting a survey of the local population's demand for services. In contrast, the financially troubled hospital proposed to develop one new service: a program to care for ventilator-dependent patients.

## B. PROJECT IMPLEMENTATION

### 1. Start-Up Success and Difficulties

Both hospitals began implementing the projects they had proposed well before they won Rural Health Care Transition grants. The hospital with multiple program objectives for the grant had incorporated the goals of the hospital's board of directors' long-range planning committee into its grant proposal. Some of the proposed programs were already underway when the grant was awarded, for example, the hiring of a psychiatrist. However, other programs proposed by the hospital have not started as smoothly, for example, the survey of community needs. Delays have been due primarily to the lack of staff to implement them. The staff member who coordinates the grant program has been diverted to intensive (unplanned) recruitment of family practice and obstetric physicians as a result of the recent loss of five physicians in the hospital's service area. Because replacement of the lost physicians is critical to the financial health of the hospital, administrative staff have been forced to concentrate on physician recruiting, at the expense of starting the other programs planned under their Rural Health Care Transition Grant project.

The program for ventilator-dependent patients at the other hospital also started smoothly. The program had been in the planning stages well before the grant was awarded and was given the final go-ahead when the hospital received the grant. In order to implement the program, the hospital needed to hire a number of respiratory therapists. These respiratory therapists were readily recruited due to a close relationship with a near-

by respiratory therapy school. Because of the smooth hiring process, the program served its first patient ahead of schedule.

2. Problems Encountered

The project activities of both grantees have run into roadblocks not anticipated by the hospitals. The hospital with multiple programs had proposed to implement a swing-bed program. State regulations on the swing-bed program had not been finalized at the time of the site visit, but based on preliminary drafts of the state regulations concerning swing bed staffing it appeared that the swing-bed program would be prohibitively expensive for the hospital. The admitting physicians were disappointed because they felt that the swing-bed program could have alleviated the dearth of skilled nursing beds in the area. However, as the hospital administrator noted, he cannot afford to undertake money-losing projects.

The hospital with the program for ventilator-dependent patients has also been set back due to legislative changes not anticipated by the hospital. In this case, the repeal of the Medicare Catastrophic Coverage Act affected the financial viability of the project. Prior to the repeal, the hospital expected to collect Medicare reimbursement for up to 150 days of skilled nursing care per calendar year for each ventilator-dependent patient. Since the repeal of the Act, the amount of skilled nursing coverage is limited to 100 days in a "spell of illness" for each patient. Since the ventilator dependent patient is expected to be in the program continuously until the end of his or her life, (i.e., the "spell of illness" will not end) the patient will be eligible for only 100 days of Medicare coverage. Thus, although the social

services department has found that it can identify patients who desire to be in the program, few of them have adequate payment coverage. The program has not enrolled as many patients as had been expected, and it has become a financial drain on the hospital because of the low patient-to-staff ratio.

## C. CHANGES IN THE SCOPE OF WORK

Because the two site visits took place within 4 months of the hospitals being awarded their Rural Health Care Transition grants, we had not expected that there would have been any changes in the scope of the projects. However, during the site visits, we found that one of the hospitals intended to request a change in scope. This was the hospital that proposed to implement multiple programs. One of the hospital's proposed programs was to implement discharge planning jointly with the County Board of Public Health (the sole home health agency in the area). After the grant was awarded, the County Board of Public Health obtained sufficient funds to implement discharge planning without financial assistance from the hospital. Therefore, the hospital indicated that it planned to request a change in scope so that funds originally intended for discharge planning could be reallocated to physician recruitment. This reallocation was approved by HCFA. Thus, the hospital's unanticipated good fortune in one area allowed it to reallocate its award to address a critical issue which evolved after the grant proposal was submitted.

## D. EXPENDITURES

Neither hospital had drawn on grant funds at the time of the site visits, although both had expenditures eligible for grant funding which were subsequently billed to the grant.

## IV. SUMMARY OF HOSPITALS' PROGRESS AFTER 6 MONTHS

### A. SUMMARY

This report is based on reports submitted by grantee hospitals describing progress between September 15, 1989, and February 28, 1990. There are limitations inherent in self-reporting although supporting documentation for the information provided, particularly the financial expenditure data, was required of grantees. Information gathered from interviews with the hospitals' Boards of Directors, hospital administrators, hospital staff, community providers, and State and local officials during visits to two grantee hospitals is also presented.

Six months after grant award, 177 of the original 181 grantees were still operating their projects. Three hospitals declined their grants and one hospital's grant was terminated when it ceased operation as an acute care facility. One financially troubled grantee has changed the scope of its grant project from a home care service program to needs assessment. Completed reports with the necessary back-up documentation were received timely from 135 of the 177 grantees.

About half of the hospitals' projects were on schedule after 6 months. Success in recruiting and filling a local service need were the two factors grantees associated with being ahead of schedule.

Hospitals were asked to indicate the factors contributing to success and problems in starting up and operating their projects. One third or more of the hospitals identified the following as important facilitating factors:

- The grant funds
- Cooperation with State and local government agencies and other providers
- Dedication of hospital staff
- Community support

The single most important factor hindering the grant projects is staffing shortages; either loss of key staff or inability to recruit staff. Other problems encountered are regulatory difficulties, lack of community support, and lack of cooperation from other organizations.

The majority of hospitals initiated their grant projects slowly. Expenditures after 6 months were only 23 percent of the first year grant allocation of $8,109,828 and 10 projects had spent no grant monies. Only eight projects had spent more than three-quarters of their first year grant (and one had spent the entire first year funds).

The largest grant expense was on personnel. Despite the limitation that only one third of funds may be spent on capital items, 57 hospitals purchased equipment such as transportation vehicles and laboratory equipment, and 11 hospitals embarked on renovation and construction projects.

# V. ACTIVITIES FOR THE NEXT 6 MONTHS

## A. SITE VISITS

During the 2 year grant period a total of 50 site visits will take place. Two visits have already been made (see Chapter III), and 18 more visits will take place in the next 6 months. Sites to be visited will be selected to represent different regions of the country, both individual and consortium projects, projects that are doing well and those that are having problems, and hospitals that are under different forms of management.

The site visits will collect comprehensive information on the projects' successes and failures and the causes of these successes and failures. We will also examine the impact of the project on the hospital and surrounding community, as well as reviewing expenditures and records and collecting data on the general conditions and problems facing rural hospitals.

## B. REPORTS

The next (third) report on the grant program will cover a number of topics. It will describe the projects' progress from March 1, 1990, to August 31, 1990, based on hospital reports and 18 comprehensive site visits. Also, it will provide background information on the grantee hospital characteristics based on reports due from the hospitals on June 15, 1990. This information, in concert with the information gathered from a full year of project operation, will allow a detailed analysis that has not been possible to date.